

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/16/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155477	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/12/2014
NAME OF PROVIDER OR SUPPLIER LANE HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 LANE AVE CRAWFORDSVILLE, IN 47933		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p>INITIAL COMMENTS</p> <p>This visit was for a Recertification and State Licensure survey.</p> <p>Survey dates: September 7, 8, 9, 10, 11, 12, 2014</p> <p>Facility number: 000462 Provider number: 155477 AIM number: 100275380</p> <p>Survey team: Mary Weyls RN TC Laura Brashear RN Vickie Nearhoof RN Brooke Harrison RN (September 8, 9, 10, 11, 12, 2014)</p> <p>Census bed type: SNF/NF: 45 Total: 45</p> <p>Census payor type: Medicare: 4 Medicaid: 35 Other: 6 Total: 45</p> <p>Lane House is in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 - 3.1, in regard to the Recertification and State Licensure survey.</p> <p>Quality Review 09/15/14 by Lisa McColly</p>	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.